The Performance of the Massachusetts Health Care System Series:
Tiered Network Membership in the Massachusetts Market
Technical Notes

Tiered Network Definition

Plans that segment their provider networks into tiers, with tiers typically based on differences in the quality or the cost of care they provide, are classified as having Tiered Networks. Tiers are not considered separate networks but rather sub-segments of a payer's HMO or PPO network. A Tiered Network is different than a plan that only splits benefits by in-network vs. out-of-network; a Tiered Network will have varying degrees of payments for in-network providers. For example, a tiered HMO plan may segment a payer's HMO network into two tiers, with a member paying a $500 inpatient copay per non-emergency admission at a Tier 1 hospital and a $1,000 inpatient copay per non-emergency admission at a Tier 2 hospital.

A plan that has different cost sharing for different types of providers is not, by default, considered a Tiered Network (i.e. a plan that has a different copay for primary care physicians than for specialists would not be considered a tiered network on that criterion alone). However, if the plan has different cost sharing within a provider type depending upon the provider selected, then the plan would be consider a Tiered Network plan.

A plan need not have all provider types subject to tiering in order to be considered a Tiered Network plan for this purpose (i.e. a plan that tiers only hospitals is a Tiered Network; similarly, a plan that tiers only physicians is also considered a Tiered Network).

Contract-Membership, Commercial Premiums, Consumer Cost-Sharing, and Benefit Levels

CHIA received contract-membership, commercial premiums, consumer cost sharing, and benefit level data for 2011, 2012, and 2013 from affiliates of the following eight (8) payers:

- Blue Cross Blue Shield of MA
- CIGNA
- Fallon Health
- Harvard Pilgrim Health Care (including Health Plans, Inc.)
- Health New England
- Neighborhood Health Plan
- Tufts Health Plan
- WellPoint (UniCare)

Payer data was provided in response to an Oliver Wyman data request ("2014 Annual Premiums Data Request") that was reviewed by CHIA and forwarded to the participating payers. This request provided detailed definitions and specifications for requested membership, premiums, claims, and other pricing data; it requested payers provide data on their commercial medical products for all group sizes, including the Individual and Small Group segments of the Merged Market. Products specifically excluded from this study were: Medicare Advantage, Commonwealth Care, Medicaid, Medicare supplement, Federal Employee Health Benefit Program (FEHBP), and non-medical (e.g., dental) lines of business.

CHIA requested membership data from payers' fully- and self-insured business, as contracted in Massachusetts. Reported members may, however, reside inside or outside of Massachusetts; out-of-state members are most often covered by an employer that is located in Massachusetts. These out-of-state "contract" members were included in all sections of this report related to premium trends. Premium-equivalent and claim data were not requested for self-funded business.

Payer-provided data were supplemented with reported financial data from the Supplemental Health Care Exhibit, Center for Consumer Information & Insurance Oversight (CCIIO) MLR Reporting,[1] and the Massachusetts Annual Comprehensive Financial Statement. These resources were also used in data validation.[2]

Payers provided their fully-insured annual premiums and claims by market sector and managed care type for 2011 through 2013. Payers also provided their rating factors used in the fourth quarter 2013. Member month information by age, gender, area, group size (fully-insured only), market sector, and managed care type was also provided for both fully-insured and self-insured.

Using the annual premiums and aggregate annual member months, Oliver Wyman calculated unadjusted premiums per member per month (PMPM). Cost-sharing PMPM was calculated by subtracting aggregate incurred claims from aggregate allowed claims and dividing that difference by aggregate member months.

To calculate "adjusted premiums", unadjusted premiums were recalculated to account for membership differences in age, gender, area, and benefits. Adjustments were performed by first adjusting the rating factors to make each payer's factors relative to a common demographic. Age/gender factors were relative to a 35 year old female and area factors were relative to Boston. A member weighted average adjusted factor was calculated for each calendar year. Finally, the unadjusted premiums were divided by the average rating factors to develop expected premiums PMPM, adjusted to the characteristics represented by a 1.0 factor.

It is possible that using the fourth quarter 2013 factors for all periods in the study had a slight impact on resulting adjusted premium trends. However, it was determined that it was not feasible to request factors for each quarter. Furthermore, the factors are applied based upon effective date of issue or renewal which was not feasible to model in this analysis. It is similarly possible that using carrier-specific rating factors had a small impact on combined market totals. However, it was determined that carrier-specific rating factors provide the best indicator of carrier-specific adjusted premiums and trends. Neither methodological decision is anticipated to materially skew adjusted premium results.

Note that for this analysis, rating factors applied to Mid-Size, Large, and Jumbo groups reflected a premium based on a manual rate and not on the group's own experience. In the market, actual premiums would be based on a combination of the manual rate and an experience rate with the proportion of each depending on the group's size. The largest groups are typically rated based entirely on their own experience. Therefore, this

[1] The Affordable Care Act requires health insurance companies to report the percentage of premium revenue that they spend on medical claims—their MLRs—to CCIIO, which publishes the data on its website.
[2] The analysis in this report relies on premium, claims, and membership data submitted by major Massachusetts payers. These data were reviewed for reasonableness, but they were not audited. When reported data were not consistent, revised data were requested and provided by the payers. To the extent that final data were unknowingly incomplete or inaccurate, findings may be compromised.

analysis makes the assumption that actual experience will follow the claim pattern assumed in the manual rating factors; actual premiums may differ. This approach is not anticipated to have a material impact on results. Rather, it is anticipated that the manual rate would be determined consistent with the overall average experience of the covered groups.

Adjusting the premiums for benefits required a separate analysis from the rating factor adjustments. Benefit levels are measured by Actuarial Values (AV), a measure of the proportion of expenditures covered by insurance versus patient cost-sharing, which can be calculated by several different methods to produce similar results. For the "adjusted premiums" analysis, Oliver Wyman's proprietary pricing model was used to estimate the AVs. To adjust for benefit levels, first, the detailed product descriptions provided for the Individual and Small group markets were priced using the proprietary pricing model, with results summarized by payer, market sector, and year, and compared to the ratio of paid claims to allowed claims based on the data provided by the payers. The model was calibrated using this comparison. The calibrated pricing model was then used to estimate the AV of benefits based on a given reported paid to allowed claims ratio. The unadjusted premiums were divided by the estimated AVs to determine the premiums adjusted for benefits. An AV of 1.0 represented a plan where 100% of the claims' costs are paid for by the plan. Given the limitations of the data available, this analysis did not include limited network impact in the AV.

The "benefit level" calculation in the DataBook represents actuarial values calibrated to the paid/allowed ratio for the total market in 2011. This calculation method differs from CHIA's 2013 Annual Report on the Massachusetts Health Care Market, though trends remain consistent.

Payer Retention and Rebates

Payer retention is the difference between the total premiums collected by payers and the total spent on incurred medical claims. Total retention amounts were based on premium and claim data reported by payers in the "2014 Annual Premiums Data Request".

Throughout this Briefing and DataBook, premiums and retention amounts are presented net of Medical Loss Ratio (MLR) rebate payments.[3] *Adjusted* premiums, however, are presented before rebates are subtracted. Paid rebate information was based on premium data provided by the payers. The payer-reported rebates were compared to Massachusetts MLR Reports filed with the Division of Insurance and were found to be consistent with the approved amounts. Where payer reported rebate information differed from the amounts reported to CCIIO, the profit as reported to CCIIO was adjusted such that the total retention was unchanged. Retention findings are for the fully-insured market and are based on Massachusetts residents and out-of-state residents covered under Massachusetts contracts.

[3] Medical Loss Ratios (MLR) represent the proportion of a plan's total collected premium spent by that plan on covering member medical claims. They also account for quality improvement and fraud detection expenses to adjust claims, and taxes and fees to adjust premiums. When a payer's spending does not meet required MLRs – which vary depending upon federal and state regulations and by employer group size - payers issue rebates to qualifying members.